Family and Friends Transportation Reimbursement Program Trip Log

Email, Mail or Fax completed logs to:

Email: payme@mtm-inc.net

MTM, Attention: Trip Logs
16 Hawk Ridge Dr.
Lake St. Louis, MO 63367

Fax: 1-888-513-1610

Instructions:

- You must call MTM at 888-597-1192 before your medical appointment. You will receive a trip number during this call. You will need to write the number down on this Trip Log. To be reimbursed, you must submit a Trip Log for all trip requests.
- Submit Trip Logs no more than 60 days past the date of the first appointment.
- Any healthcare professional at the facility can sign the Trip Log. *This includes nurses, therapists, physician assistants, or nurse practitioner*s. It doesn't have to be the doctor.
- We suggest you make copies of your blank NH Family and Friends Transportation Reimbursement Trip Log. If you need a new copy of this form, you may call and request one be mailed to you, or you may download this form at https://www.mtm-inc.net/mileage-reimbursement/
- A one-way trip is from your home to the appointment. A round trip is from your home to the appointment and then back home. For trips with more stops, such as an extra trip from the first appointment to a second appointment before going back home, please enter each trip leg on a separate line, for example:
  - 1st leg- home to first doctor
  - 2nd leg- first doctor to second doctor
  - 3rd leg- second doctor to home
- If you don't have a Trip Log, ask your healthcare professional for a note on their facility letterhead. The note should state that you were seen and the date of the appointment. Once you have a new trip log, attach the note from your healthcare provider in place of a signature.
- Incomplete forms cannot be processed. It is your responsibility to complete this form correctly.
- Keep a copy of your Trip Log for your records.
- **Questions about the Reimbursement Process?** Please call: **1-888-513-0703.**

Member Info	First Name:	Last Name:		Medicaid #:
	Address:			Phone:
	City:		State:	Zip:
Payment Info	Make payment to:			Date of Birth:
	Address:			Phone:
	City:		State:	Zip:

nh healthy families. MTM

Family and Friends Transportation Reimbursement Program Trip Log (Continued)

Trip #1	Trip Number (Call MTM for this before your trip):	Appointment Date:	Appointment Time:	Type: ☐ Round Trip ☐ One-Way
	Address where you were picked up: ☐ Home ☐ Other:			Healthcare Provider Phone:
	Healthcare Provider Name:	Healthcare Provider Address:		
	I certify that this patient was seen for a Medicaid covered health service.	**Signature & Title of Healthcare Provider:** ▶		
Trip #2	Trip Number (Call MTM for this before your trip):	Appointment Date:	Appointment Time:	Type: ☐ Round Trip ☐ One-Way
	Address where you were picked up: ☐ Home ☐ Other:			Healthcare Provider Phone:
	Healthcare Provider Name:	Healthcare Provider Address:		
	I certify that this patient was seen for a Medicaid covered health service.	**Signature & Title of Healthcare Provider:** ▶		
Trip #3	Trip Number (Call MTM for this before your trip):	Appointment Date:	Appointment Time:	Type: ☐ Round Trip ☐ One-Way
	Address where you were picked up: ☐ Home ☐ Other:			Healthcare Provider Phone:
	Healthcare Provider Name:	Healthcare Provider Address:		
	I certify that this patient was seen for a Medicaid covered health service.	**Signature & Title of Healthcare Provider:** ▶		
Trip #4	Trip Number (Call MTM for this before your trip):	Appointment Date:	Appointment Time:	Type: ☐ Round Trip ☐ One-Way
	Address where you were picked up: ☐ Home ☐ Other:			Healthcare Provider Phone:
	Healthcare Provider Name:	Healthcare Provider Address:		
	I certify that this patient was seen for a Medicaid covered health service.	**Signature & Title of Healthcare Provider:** ▶		
Trip #5	Trip Number (Call MTM for this before your trip):	Appointment Date:	Appointment Time:	Type: ☐ Round Trip ☐ One-Way
	Address where you were picked up: ☐ Home ☐ Other:			Healthcare Provider Phone:
	Healthcare Provider Name:	Healthcare Provider Address:		
	I certify that this patient was seen for a Medicaid covered health service.	**Signature & Title of Healthcare Provider:** ▶		
Trip #6	Trip Number (Call MTM for this before your trip):	Appointment Date:	Appointment Time:	Type: ☐ Round Trip ☐ One-Way
	Address where you were picked up: ☐ Home ☐ Other:			Healthcare Provider Phone:
	Healthcare Provider Name:	Healthcare Provider Address:		
	I certify that this patient was seen for a Medicaid covered health service.	**Signature & Title of Healthcare Provider:** ▶		
Trip #7	Trip Number (Call MTM for this before your trip):	Appointment Date:	Appointment Time:	Type: ☐ Round Trip ☐ One-Way
	Address where you were picked up: ☐ Home ☐ Other:			Healthcare Provider Phone:
	Healthcare Provider Name:	Healthcare Provider Address:		
	I certify that this patient was seen for a Medicaid covered health service.	**Signature & Title of Healthcare Provider:** ▶		
I have completed this form and I verify that the information on this trip log is true.		**Signature of Member, Parent/Legal Guardian, or Representative:** ▶		

Trip Log Revised August 2020. This communication contains information that is confidential and is solely for the use of the intended recipient. It may contain information that is privileged and exempt from disclosure under applicable law. If you are not the intended recipient of this communication, please be advised that any disclosure, copying, distribution, or unauthorized use of this communication is strictly prohibited. Please also notify MTM at 1-888-561-8747 and return the communication to the originating address. If you, or someone you're helping, has questions about MTM, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 888-561-8747.

Si usted, o alguien a quien usted esté ayudando, tiene preguntas acerca de MTM, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 888-561-8747. Non-discrimination. The client has a right to receive services in compliance with Title VI of the Civil Rights Act of 1964, 42 U.S.C.A., 2000d, et seq; 504 of the Rehabilitation Act of 1973, 29 U.S.C.A. 794; the Americans with Disabilities Act of 1990, 42 U.S.C.A. 12101, et seq; and all amendments to each, and all requirements imposed by the regulations issued pursuant to these Acts, in particular 45 C.F.R. Part 80 (relating to race, color, national origin), 45 C.F.R. Part 84 (relating to handicap), 45 C.F.R. Part 86 (relating to sex), and 45 C.F.R. Part 91 (relating to age).

Other Languages Available

Spanish: Si usted o alguien a quien está ayudando tiene preguntas sobre NH Healthy Families, tiene derecho a recibir ayuda e información en su idioma sin costo. Para hablar con un intérprete, llame al 1-866-769-3085 (TDD/TTY 1-855-742-0123)

French: Si vous, ou une personne que vous aidez, avez des questions sur NH Healthy Families, vous avez le droit d'obtenir de l'aide et des informations dans votre langue sans frais. Pour parler à un interprète, composez le 1-866-769-3085 (ATS/ATME 1-855-742-0123)

Chinese: 如果您自己或您帮助的人对 NH Healthy Families 有疑问，则有权以您所用语言免费获取帮助和信息。要与口译员对话，请致电 1-866-769-3085 (TDD / TTY 1-855-742-0123)

Vietnamese: Nếu quý vị, hoặc ai đó mà quý vị đang giúp đỡ, có câu hỏi về NH Healthy Families, bạn có quyền nhận sự trợ giúp và thông tin bằng ngôn ngữ của bạn miễn phí. Để nói chuyện với một thông dịch viên, hãy gọi số 1-866-769-3085 (TDD / TTY 1-855-742-0123)

Portuguese: Se você, ou alguém que você estiver ajudando, tiver dúvidas sobre o NH Healthy Families, é seu direito obter auxílio e informações no seu idioma, gratuitamente. Para falar com um intérprete, ligue para 1-866-769-3085 (atendimento a deficientes auditivos: 1-855-742-0123)

Greek: Εάν εσείς, ή κάποιο άτομο που βοηθάτε, έχετε ερωτήσεις σχετικά με το πρόγραμμα NH Healthy Families, έχετε δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας δωρεάν. Για να μιλήσετε με διερμηνέα, τηλεφωνήστε στο 1-866-769-3085 (1-855-742-0123 για άτομα με βαρηκοΐα)

Arabic: استفسارات ك أو لدى شخص تقدم له مساعدة حول إذا لد كانت NH Healthy Families، حق لك الحصول

 ع اتصل ،جم

1-866-769- .ا مع للتحدث 3085 مجان بلغتك والمعلومات المساعدة ع (TDD/TTY 1-855-742-0123).

Serbo-Croatian: Ukoliko vi , ili neko kome pomažete, ima pitanja o NH Zdravim porodicama, imate pravo da dobijete pomoć i informacije na vašem jeziku bez troškova. Da biste pričali sa tumačem, pozovite 1-866-769-3085 (TDD / TTY 1-855-742-0123)

Indonesian: Jika Anda, atau orang yang Anda bantu, ingin mengajukan pertanyaan tentang NH Healthy Families (Keluarga Sehat NH), Anda berhak mendapatkan bantuan dan informasi dalam bahasa Anda tanpa biaya. Untuk berbicara dengan juru bahasa, telepon 1-866-769-3085 (TDD/TTY 1-855-742-0123). TDD = Telepon untuk tunarungu, TTY = Telepon teks

Korean: 귀하 또는 귀하가 돕고 있는 사람이 NH 헬시 패밀리즈(NH Healthy Families)에 관해 질문이 있는 경우, 귀하는 무료로 귀하의 언어로 도움과 정보를 얻을 권리가 있습니다. 통역사와 대화하시려면 1-866-769-3085 (TDD / TTY 1-855-742-0123)로 전화하십시오

Russian: Если у Вас или у кого-либо, кому Вы помогаете, появятся вопросы относительно страхования в NH Healthy Families (Здоровые семьи в штате Нью-Гэмпшир), Вы имеете право бесплатно получить помощь и информацию на Вашем языке. Для того чтобы поговорить с переводчиком, позвоните 66-769-3085 (Устройства для людей с нарушением слуха (TDD / TTY) 1-855-742-0123)

French Creole: Si oumenm, oswa yon moun w ap ede, genyen kesyon konsènan NH Healthy Families/Fanmi an Sante, ou genyen dwa pou jwenn èd ak enfòmasyon gratis nan lang pa ou. Pou pale ak yon entèprèt, rele 1-866-769-3085 (pou moun ki soud/pa tande byen 1-855-742-0123)

Bantu: Kana iwe, kana kuti munhu wauri kubatsira, muine mibvunzo maererano nezve NH Healthy Families, munekodzero yekuwana rubatsiro neruzivo, muchirudzi chenyu pasina mibhadharo inotarisirwa kwamuri. Kutaura nemuturiki, munotibata panhamba dzinotevera dzinoti 1-866-769-3085 (TDD/TTY 1-855-742-0123)

Polish: Jeśli Ty lub ktoś, komu pomagasz, ma pytania dotyczące NH Healthy Families, masz prawo do uzyskania pomocy i informacji w swoim języku bez ponoszenia żadnych kosztów. Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-866-769-3085 (TDD/TTY 1-855-742-0123)

Statement of Non-Discrimination

NH Healthy Families complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, or sexual orientation. NH Healthy Families prohibits discrimination on grounds of age, race ethnicity, mental or physical disability, sexual or affection orientation or preference, marital status, genetic information, source of payment, sex, color, creed, religion or national origin or ancestry. NH Healthy Families does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

NH Healthy Families:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact NH Healthy Families at 1-866-769-3085 (TDD/TTY 1-855-742-0123.)

NH Healthy Families prohibits discrimination on grounds of age, race, ethnicity, mental or physical disability, sexual or affection orientation or preference, marital status, genetic information, source of payment, sex, color, creed religion, or national origin or ancestry. If you believe that NH Healthy Families has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Grievances and Appeals Coordinator, NH Healthy Families, 2 Executive Park Drive, Bedford, NH 03102, 1-866-769-3085 (TDD/TTY 1-855-742-0123), Fax 1-866-614-1951.

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, NH Healthy Families is available to help you. You may also file a discrimination complaint through the DHHS Office of the Ombudsman who has been designated to coordinate the efforts of NH DHHS's civil rights compliance for the Department: State of New Hampshire, Department of Health and Human Services, Office of the Ombudsman, 129 Pleasant Street, Concord, NH 03301-3857; (603) 271-6941 or (800) 852-3345 ext. 6941, FAX (603) 271-4632, TDD Access: relay NH 1-800-735-2964; E-mail: ombudsman@dhhs.nh.gov.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, Complaint forms are available at https://www.ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).